

MOTOR ACCIDENT CLAIM FORM



Insurance Brokers

Insurer:

Insured:

Policy No:

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| Insured | <p>Name: <input type="text"/></p> <p>Address: <input type="text"/> <input type="text"/> <small>POSTAL CODE</small> <input type="text"/></p> <p>Day Tel No.: <input type="text"/></p> <p>ID No: <input type="text"/> VAT No: <input type="text"/></p> |
| Vehicle | <p>Make: <input type="text"/></p> <p>Model: <input type="text"/> Kilometers Completed: <input type="text"/></p> <p>Registration No: <input type="text"/> Value: <input type="text"/></p> <p>Year: <input type="text"/> Date of Purchase: <input type="text"/> <input type="text"/></p> <p>In whose name is the car registered? <input type="text"/></p> |
| Damage | <p>Damage to Own Vehicle: <input type="text"/> <input type="text"/></p> <p>Damage Estimate: <input type="text"/></p> <p>Repairer's Name: <input type="text"/> Repairer's Tel: <input type="text"/></p> <p>Where can your damaged vehicle be inspected? <input type="text"/> <input type="text"/></p> |
| Driver | <p>Full Name: <input type="text"/></p> <p>Residential Address: <input type="text"/> <input type="text"/> <small>POSTAL CODE</small> <input type="text"/></p> <p>Occupation: <input type="text"/></p> <p>ID No: <input type="text"/></p> <p>Driving Licence: <input type="text"/> <small>DATE ISSUED</small> <input type="text"/> <small>CODE</small> <input type="text"/></p> <p>State fully the purpose for which the vehicle was in use: <input type="text"/> <input type="text"/></p> <p>Was he/she driving with your permission? <input type="text"/> YES <input type="text"/> NO Was he/she in your employ? <input type="text"/> YES <input type="text"/> NO</p> <p>Details of any convictions for motoring offences: <input type="text"/> <input type="text"/></p> <p>Has licence ever been endorsed? <input type="text"/> YES <input type="text"/> NO</p> <p>Details of any previous accidents: <input type="text"/> <input type="text"/> <input type="text"/></p> |

| Passengers | <p>PASSENGERS IN INSURED VEHICLE</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">NAME</th> <th style="width: 50%;">RESIDENTIAL ADDRESS</th> <th style="width: 25%;">INJURY</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>For what purpose were they carried? <input style="width: 80%;" type="text"/></p> <p>Are they employees? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | NAME | RESIDENTIAL ADDRESS | INJURY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------------|---|----------------------------------|--------------------------|---------------------|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|------------------|------|----------------------------------|--------|--|--|--|--|--|--|--|--|--|--|--|--|---------------------------|-------------------|--|--|--|--|--|--|
| NAME | RESIDENTIAL ADDRESS | INJURY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Other Party | <p>PERSONAL INJURIES (OTHER THAN IN INSURED VEHICLE)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">INJURIES</th> <th style="width: 25%;">NAME OF INJURED</th> <th style="width: 25%;">DRIVER OR PASSENGER</th> <th style="width: 25%;">HOSPITAL (IF APPLICABLE)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>This accident must be reported to the Multilateral Motor Vehicle Fund using the special accident report form (MMF3) within 14 days if there is any likelihood of injuries, otherwise the Fund may be able to recover from you. Their address is P O Box 2743, Pretoria, 0001.</p> <p>OTHER VEHICLES</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">REGISTRATION No.</th> <th style="width: 15%;">MAKE</th> <th style="width: 40%;">NAME AND ADDRESS OF OWNER/DRIVER</th> <th style="width: 20%;">DAMAGE</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>PROPERTY OTHER THAN VEHICLES</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 55%;">NAME AND ADDRESS OF OWNER</th> <th style="width: 45%;">DETAILS OF DAMAGE</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> | INJURIES | NAME OF INJURED | DRIVER OR PASSENGER | HOSPITAL (IF APPLICABLE) | | | | | | | | | | | | | REGISTRATION No. | MAKE | NAME AND ADDRESS OF OWNER/DRIVER | DAMAGE | | | | | | | | | | | | | NAME AND ADDRESS OF OWNER | DETAILS OF DAMAGE | | | | | | |
| INJURIES | NAME OF INJURED | DRIVER OR PASSENGER | HOSPITAL (IF APPLICABLE) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| NAME AND ADDRESS OF OWNER | DETAILS OF DAMAGE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Witness | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">NAME</th> <th style="width: 40%;">ADDRESS</th> <th style="width: 30%;">TEL No.</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> | NAME | ADDRESS | TEL No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME | ADDRESS | TEL No. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Accident | <p>POLICE DETAILS</p> <p>Name of Officer: <input style="width: 80%;" type="text"/></p> <p>Police Station: <input style="width: 20%;" type="text"/> Ref No: <input style="width: 20%;" type="text"/></p> <hr style="border-top: 1px dashed black;"/> <p>Date: <input style="width: 15%;" type="text"/> Time: <input style="width: 15%;" type="text"/> Place: <input style="width: 60%;" type="text"/></p> <p>Speed before accident: <input style="width: 15%;" type="text"/> KM/H Speed at moment of impact: <input style="width: 15%;" type="text"/> KM/H</p> <p>Weather Conditions: <input style="width: 30%;" type="text"/> Visibility: <input style="width: 30%;" type="text"/></p> <p>Road Surface: <input style="width: 30%;" type="text"/> Width of Road: <input style="width: 30%;" type="text"/></p> <p>Vehicle Lights in Use: <input style="width: 30%;" type="text"/> Street Lights: <input style="width: 30%;" type="text"/></p> <p>Was any warning given by you, eg. Hooping, indicators, etc. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Was the driver tested for alcohol or drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

